

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 02/08/01?
- b. The request was received on 02/07/02.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution dated 03/15/02
 - b. HCFA's
 - c. EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and Response to a Request for Dispute Resolution
 - b. HCFA's
 - c. Audit summaries/EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 02/10/02. The response from the insurance carrier was received in the Division on 02/21/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

The Provider...“charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services.” The provider is seeking additional reimbursement in the amount of \$5,213.31 for the date of service 02/08/01.

2. Respondent:

“The charges submitted by the Provider for date of service 2-8-01 were paid according to fee guidelines.” The Carrier denies additional reimbursement in the amount of \$5,213.31 for the date of service 02/08/01.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 02/08/01.
2. The Provider billed the Carrier \$10,246.11 for the date of service 02/08/01.
3. The Carrier reimbursed the Provider \$1,788.80 for the date of service 02/08/01.
4. The amount in dispute is \$5,213.31 for the date of service 02/08/01.

V. RATIONALE

Medical Review Division's rationale:

Per the Texas Workers' Compensation Act and Rules **§413.011**:

“(b) Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by the individual or by someone acting on the individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.”

The Requestor's UB-92's showed an ICD-9 Code of 724.2 (Lumbago). Example EOBs from other insurance carriers submitted showed an ICD-9 Code of 724.2. Three EOBs from other insurance carriers show that the provider had been paid for treatment of an individual of equivalent standard of living and paid by “...someone acting on that individual's behalf...” and this conforms with the criteria in Sec. 413.011 (d). The Requestor has provided information that indicates reimbursement of 58% of billed charges would be fair and reasonable.

The Respondent's documentation fails to support the Respondent's position that the amount it paid to the Requestor was fair and reasonable. TWCC § 134.401(a)(4) states: "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursement." The Respondent has failed to establish their reimbursement for date of service, 02/08/01, was fair and reasonable. Therefore, additional reimbursement in the amount of \$4,153.94 is recommended. **$(\$10,246.11 \times 58\% = \$5,942.74) (\$5,942.74 - \$1,788.80 = \$4,153.94)$** .

The above Findings and Decision are hereby issued this 19th day of April 2002.

Michael Bucklin, LVN
Medical Dispute Resolution Officer
Medical Review Division

MB/mb

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$4,153.94 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 19th day of April 2002.

Carolyn Ollar, R.N., B.A.
Medical Dispute Resolution Officer
Medical Review Division

CO/mb